DELAWARE SURGERY CENTER

200 Banning Street, Suite 110. • Dover, DE 19904

Dear Patient:

Thank you for choosing Delaware Surgery Center and allowing us to participate in your care. You are receiving this letter and information because it has been identified that you either do not have medical insurance or have a patient responsibility that exceeds your ability to pay.

During your visit you may receive services from the other contracted healthcare professionals such as your surgeon, an anesthesia provider and pathology. These services are billed separately by those individual physicians and/or laboratories.

Enclosed please find a Financial Assistance Application from the Delaware Surgery Center for your surgical procedure(s) and Anesthesia Services, PA for your anesthesia services. If you wish to have the expenses for the procedure at Delaware Surgery Center and your Anesthesia service considered for a reduction, please complete both forms in their entirety and return with the required financial documents. Please note we are required to request the documents in order to comply with IRS regulation standards for reduction of our normal fees. All information will be kept confidential. Delaware Surgery Center does not make financial assistance determinations for Anesthesia Service, PA. However, our staff will forward your application and financial documents to the provider for consideration. You may contact their office directly at 1-855-792-2772.

Please call our office should have any questions. Again, thank you for allowing us to participate in your care.

Sincerely,

Delaware Surgery Center Billing & Accounts Receivable Department
Phone: 302.741.2402
Fax: 302.741.2449

Delaware Surgery Center, LLC

200 Banning Street, Suite 110, Dover, DE 19904
Telephone: 302.741.2402 • Fax: 302.741.2449

Financial Assistance Application

I am applying for the Delaware Surgery Center Financial Assistance Program. I am providing the following documentation for determination of eligibility. I understand that completing the information on this form does not guarantee that I qualify or that I am eligible to receive financial assistance.

Patient Name: _____ Surgeon Name:_____

Procedure to be performed: _____ Date of Service, if know: _____

Address: _____

City/State/Zip: _____ Telephone: _____

Responsible Party (if different than patient):_____Relationship: _____

****Monthly Household Income includes Salary/Wages, Social Security, Pensions, annuities, dividends, alimony, child support, etc. (Includes all persons in household that bring income into the home.) Please attach copy of pay stub, unemployment stub, or some other proof of income, & copy of last tax return if you are required to file.**

	Self	**Spouse**	**Other: _____**
**Monthly Household Income:	$_____	$_____	$_____

Number of Dependents Claimed on Tax Form: _____ Marital Status: _____

Name and Age of Persons Living in Household:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you have Medical Insurance (including Medicaid or Medicare) Coverage: ☐ Yes ☐ No
Do you have a Community Healthcare Access Program (CHAP) ID Card? ☐ Yes ☐ No

Other circumstances that you feel may be pertinent and you or your referring physician believes should be considered in making determination: _____

_____

_____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will provide all insurance information that may be available for payment of my surgical charges. I will also take any action reasonable necessary to obtain such insurance assistance.

I understand that this application is made for Delaware Surgery Center to judge my eligibility for financial assistance. If financial assistance is approved, I understand that the center may verify any of the above information and I grant my permission for such verification and agree to assist in any way request. If any information I have given proves to be unsupported, I understand that Delaware Surgery Center will re-evaluate my financial ability and the full amount of my bill may become due and payable.

In the event your financial assistance does not cover the services in full, I agree to make monthly payments on the remaining balance, after all insurance have been paid, in the amount to be determined by Delaware Surgery Center which will be based on my financial eligibility.

Patient/Guardian Signature: _____ Date: _____

Delaware Surgery Center Billing Department Use Only (See Financial Assistance Calc Form): ☐ Approve ☐ Deny